HCFA MEDICARE • MEDICAID Health Care Financing Administration

Volume V, Number 1 September 1999

HEALTH watch

Medicare Proposes 2000 Physician Fee Schedule

HCFA's proposed physician fee schedule for calendar year 2000 that continues the transition to a fairer physician payment system can be found in the July 22 issue of the *Federal Register.* The final version will be published in the fall.

Continuing the reforms initiated in the 1999 fee schedule, the proposed fee schedule relates payment for physician practice expenses to the actual resources used to provide medical services rather than physicians' historical charges.

"Breaking the link between Medicare practice expense payments and historical charges will create a fairer payment system," said HCFA Deputy Administrator Michael Hash. "The

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Celebrating the Launch of Healthy People 2010

U.S. Surgeon General and Assistant Secretary for Health Dr. David Satcher invites you to join in the Partnerships for Health in the New Millennium Conference celebrating the launch of new national health objectives, Healthy People 2010, on January 24–28, 2000 in Washington, D.C. Partnerships for Health in the New Millennium will be the first national health promotion conference of the new century. It will focus on four themes: Partnering for Health Improvements, Eliminating Health Disparities, Increasing Quality and Years of Healthy Life, and Harnessing Technology for Health.

In addition to plenary sessions, an important feature of the conference will be the breakout, caucus and poster sessions, which will be an invaluable opportunity for information sharing and networking. Information about registering as an exhibitor or participating in the Technology Games is available on the Web site at ***www.health.gov/partnerships.***

The Partnerships for Health in the New Millennium Conference is being convened by the Healthy People Consortium and the Partnerships for Networked Consumer Health Information. Over 1,200 participants with diverse backgrounds from public health, health care, academic and research institutions, employers, technology companies, faith and advocacy organizations, government agencies, and health care consumers will be gathering.

The Healthy People Consortium is made up of more than 350 national membership organizations. In addition, 270 State and Territorial public health, mental health, environmental health, and substance abuse departments are in the consortium.

Also sponsored by HHS, Partnerships for Networked Consumer Health Information is a public-private partnership that promotes development of interactive telecommunication and computer technologies that help consumers take greater responsibility for their health.

The Health Care Financing Administration's Dr. Marsha Davenport is a member of the Healthy People Consortium and has provided input during the public comment periods. In addition, Davenport is a member of the planning committee for the conference, along with HCFA's Betty Burrier, Sheila Fleckenstein and Debbi Oxenreider.◆

For more information call 1-800-367-4725, E-mail ***partnerships@health.org*** or go online to ***www.health.gov/partnerships.*** To subscribe to the conference listserv send an E-mail to ***listserv@list.nih.gov*** with the following text in the message body: SUBSCRIBE partnerships-00 YOUR NAME.

Mary Jo Deering, Ph.D., Director of Health Communications and Telehealth at the Office of Disease Prevention and Health Promotion, contributed this article.

HEALTH watch

The *HCFA Health Watch* is published monthly, except when two issues are combined, by the Health Care Financing Administration (HCFA) to provide timely information on significant program issues and activities to its external customers.

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Immunize yourself against ***FLU*** complications. Get a ***SHOT*** soon.

Message from the DeputyAdministrator

MICHAEL M. HASH

LET ME RECOMMEND A WEB SITE TO YOU. The address is ***www.insurekidsnow.gov***. It will open your eyes to one of the most exciting things we're doing at HCFA, working with the states to provide health care for America's children through the Children's Health Insurance Program (CHIP).

President Clinton signed the law that created CHIP just two years ago. Today, thanks to CHIP, more than a million of America's children are getting the health care they need. CHIP kids are mostly children of the working poor — families with too much income to qualify for regular Medicaid but too little for them to purchase private health insurance. CHIP was designed to reach those kids, and so far it's right on the mark.

Just recently, President Clinton and the National Governors' Association launched an Insure Kids Now Hotline, 1-877-KIDS-NOW, and the new Web site. The national toll-free telephone number automatically routes calls from parents and others to the proper state agency for information about free or low-cost health insurance for children available in their communities.

The Web site offers information on children's health insurance in each state or territory, information on how to apply for coverage, and guidelines for whether families might qualify for a plan. CHIP has truly been a cooperative effort. Each state tailored a CHIP program best suited to reach its own uninsured children. The states also named their CHIP programs, so now we have New Mexikids, Florida KidCare, SoonerCare, and so on.

States had the options of designing a new children's health insurance program, expanding their Medicaid programs, or using a combination of the two — and all three approaches have been applied successfully.

Today there are 52 CHIP programs in the states, territories, and the District of Columbia. Three additional states have submitted plans that are now awaiting approval. And 17 states have filed amendments to upgrade their programs and cover even more kids.

If you want to get involved in CHIP (and I hope you do), our HCFA CHIP Web site will tell you about the clever outreach programs that state and local agencies have created. Georgia partnered with K-Mart so that, as parents take the kids shopping for school clothes, CHIP flyers are handed out at the door. New Jersey has a CHIP check-off box on the back of the Free and Reduced Cost Lunch application. South Carolina has CHIP brochures displayed in pharmacies all across the state. But, most importantly, HCFA's CHIP outreach page welcomes suggestions from YOU — and new ideas are always welcome.

A big CHIP "Back-to-School" campaign is in the works, and volunteers will be needed. We want to work with the states to enroll all the eligible children for CHIP. The ultimate goal is to enroll at least five million uninsured kids in either CHIP or Medicaid through outreach programs conducted by the states and their partners. So take a look at the Web site, and offer your ideas. You might even volunteer to help with CHIP enrollment in your community.

Remember, our children are America's future. ◆

Hearing-Impaired Medicaid Clients

HHS Office for Civil Rights Reaches Agreement with D.C. Department of Health to Ensure Meaningful Access to Provisions of Health Services

An agreement has been reached between the District of Columbia's Department of Health and the Office for Civil Rights (OCR) of the Department of Health and Human Services to ensure that low-income persons with hearing impairments have meaningful access to critical health services and programs, such as Medicaid-funded physician's visits.

The steps taken by the D.C. Department of Health close a complaint filed with OCR by a hearing-impaired Medicaid client and an area civil rights organization representing hearing-impaired persons. The complaint alleged that the department discriminated against hearing-impaired clients on the basis of disability by not providing effective communications, including sign language interpreter services, to hearing-impaired individuals who were attempting to receive Medicaid-funded services in individual physician offices.

Policies and practices resulting in hearing-impaired clients not having an equal opportunity to participate in and benefit from programs receiving federal funds violate Section 504 of the Rehabilitation Act of 1973. OCR enforces Section 504, which prohibits discrimination on the basis of disability. In addition, under Title II of the Americans with Disabilities Act, state and local governments are obligated to ensure their programs and activities are accessible to persons with disabilities. OCR enforces Title II for state and local government health and social service programs.

Low-income District residents with hearing impairments should have the same opportunity as everyone else to communicate with their health care provider," said Thomas Perez, Director of OCR. "We are very pleased with the steps the D.C. Department of Health has taken in delivering Medicaid services to its hearing-impaired clients. This is a model for other government agencies to follow."

The D.C. Department of Health agreed to contract with a local sign language interpreter program to provide interpreter services in the offices of primary care physicians. A purchase order has been signed with Graham Staffing in the District of Columbia. The department then established procedures for physicians who participate in the Medicaid program to contact Graham Staffing when they treat hearing-impaired patients. All costs for the interpreter service are being absorbed by the D.C. Department of Health. Information regarding these procedures has been sent to various organizations within the deaf and hearing-impaired community.

At the end of the contract year the D.C. Department of Health will provide OCR with information on the number of persons served and the level of use by physicians and other primary health care providers. OCR will continue to monitor compliance with this agreement. ◆

Calendar of Speaking Engagements

September 17	Deputy Administrator Michael Hash speaks at the HCFA/ CMSO/ Boston Regional Office HIV/AIDS Coordinators and Maternal HIV/AIDS CIP Conference in Baltimore, Md., on *HCFA's Priorities for HIV/AIDS Initiatives for the Future.*
September 27	Deputy Administrator Hash addresses a HCFA/CMSO-sponsored meeting via PicureTel on *HCFA Programs.*
October 11	Center for Health Plans and Providers Director Robert Berenson addresses the American College of Surgeons in San Francisco, Calif., on *Medicare in Transition: The Implication for Surgery.*
October 14	Deputy Administrator Hash speaks at the Michigan Health & Hospital Association in Traverse City, Mich., on *Medicare Budget Cuts — What Form the Cuts Will Take, What Impact They Will Have on Hospitals and Health Systems, and What Steps Can Be Taken Now to Prepare for the Cuts.*
October 18	Deputy Administrator Hash addresses the Association of Health Facility Survey Agencies in New Orleans, La., on *HCFA Programs.*

Statement by HCFA Administrator Nancy-Ann Min DeParle on the External Review of Hospital Quality of Care for Beneficiaries

Assuring quality of care for Medicare patients has always been a top priority for the Health Care Financing Administration (HCFA). As today's Office of Inspector General (OIG) reports state, our current cooperative system of hospital oversight "has significant strengths that help protect patients."

At the same time, HCFA agrees with the Inspector General that this system needs to be even stronger. We welcome the OIG's recommendations. They are a valuable contribution during a period when we are taking a broad range of actions to assure the best care for Medicare beneficiaries.

We have incorporated the Inspector General's recommendations into our new action plan, the Hospital Quality Oversight Plan. This plan will ensure that the hospitals deliver the high quality of care patients deserve through better oversight and performance monitoring. Hospitals that fail to meet our standards will not participate in our Medicare and Medicaid programs.

We will hold the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the state survey agencies fully accountable for their performance. For example, in our revised Conditions of Participation regulations, we will clearly define our priorities for hospital surveys of basic health and safety issues such as medication errors and surgery mix-ups. We will also clarify JCAHO's responsibility in monitoring the performance of accredited hospitals and work with them to conduct more unannounced surveys and perform more rigorous assessments of each hospital's internal quality assurance process.

HCFA will also determine the appropriate minimum cycle for conducting surveys of nonaccredited hospitals. We are strongly committed to establishing a survey cycle for nonaccredited hospitals so they are surveyed as frequently as accredited hospitals.

Our work with the JCAHO and state agencies is extremely important to improve quality of care. Our oversight plan will further our goal of striking the right balance of educational and regulatory activities. ◆

New Steps That Will Build on HCFA's Current Efforts to Ensure High Quality of Care for Medicare Beneficiaries

Conditions of Participation Regulations (CoPs)	CoPs are the minimum health and safety requirements that hospitals must meet in order to participate in the Medicare and Medicaid programs. HCFA is currently revising and improving these standards to reflect advances in quality improvement that are occurring in both the public and private sectors. The final Conditions of Participation regulations, expected to be completed by fall 2000, will also incorporate the Inspector General's recommendations and HCFA's Hospital Quality Oversight Plan.
Performance Measures	HCFA is in the process of developing new, evidence-based quality measures to assure high quality hospital care for all Americans. HCFA has directed Peer Review Organizations (PROs) to establish and develop measures that will provide benchmarks of quality hospital care. Three of the performance measures under development include the rate of beta blocker drugs prescribed for patients hospitalized after a heart attack, mortality rates and infection rates following surgery. These performance measures will be an additional tool to be used in quality oversight and will complement on-site surveys by JCAHO and state survey agencies.
Information to Consumers	HCFA is committed to providing better information to consumers, so that they will be able to make better decisions in their health care choices. Traditionally, data to compare hospital performance has not been readily available; however, we are currently exploring several approaches to provide more information to Medicare beneficiaries and other consumers. For example, HCFA is currently coordinating a pilot project to examine how to develop and distribute hospital performance data that will enable consumers to compare the quality of care among hospitals.

http://www.medicare.gov/publications.html

Medicare Publications

Nineteen Medicare publications are located at this Web site for your possible reading needs. Some of these publications are in **Text Only** and some are in **Adobe Acrobat PDF format** (an exact duplication of the original with images and graphics). To read a **Text Only** file, click on the link to call the specific document to your browser. To view a publication in **Adobe Acrobat PDF**, the viewer needs to download the Adobe Acrobat Reader. ◆

Schedule, from page 1

proposed 2000 fee schedule represents an important next step in making sure Medicare pays physicians fairly. By refining the payment system to be more equitable, we help Medicare beneficiaries to stay healthy and productive by preserving access to physicians."

The fee schedule specifies payments to physicians for more than 7,000 services and procedures, ranging from routine office visits to cardiac bypass surgery. In 2000, Medicare will spend about $37 billion on physician services.

Under the proposed fee service, physicians who provide services primarily in office settings, such as family practice and internal medicine specialists, would receive slightly increased payments, while physicians who provide services primarily in the hospital setting would receive slightly decreased payments. However, because of the malpractice insurance cost adjustments, emergency department physicians would receive a 2.7 percent increase and nephrologists a 1.3 percent increase. No specialists will receive payment decreases or increases greater than 1 percent.

The resource-based practice expense component of the Medicare fee schedule is being phased in during a four-year transition period that began on January 1, 1999. Payments under the 2000 fee schedule will be based on a blend of 50 percent of the resource-based practice expenses and 50 percent of the old, charge-based system. When the resource-based practice is fully effective in 2002, all components of the fee schedule, including physician services, malpractice insurance expense and practice expense, will be resource-based, creating a more equitable system.

The proposed rule would implement the resource-based malpractice relative value units required by the 1997 Balanced Budget Act. Using data on how much various medical specialties spent on malpractice insurance, HCFA adjusted each service for the cost of malpractice insurance associated with it. This adjustment is not expected to have a significant effect on overall payments made to various medical specialties.

The proposed rules would also extend Medicare coverage for prostate cancer screening tests for all male beneficiaries effective January 1, 2000. President Clinton's June 29 proposal to modernize Medicare contained a proposal to eliminate all coinsurance and copayments associated with health screening tests. Prostate cancer is the most commonly diagnosed cancer in men and the second leading cause of death from cancer among American men.

The new payment system was prompted by studies that showed the old, charge-based system did not fairly compensate physicians for practice expenses. For example, under the old system, coronary bypass surgery would receive practice expense payments more than 100 times greater than those for an office visit, although costs for bypass surgery are only about 40 times higher.

In 1994, Congress instructed HCFA to design a similar resource-based value system for physician practice expenses.

Practice expenses are composed of direct and indirect expenses. Direct expenses include non-physician labor, medical equipment and medical supplies needed for each procedure. Indirect expenses such as the cost of general office supplies and utilities cannot be tied to individual procedures, so HCFA used accepted accounting techniques to allocate expenses to each medical procedure. Working with all major medical specialty societies, HCFA convened expert panels and conducted extensive research to estimate the direct expenses for different medical procedures and services. HCFA also used information gathered by the American Medical Association's Socioeconomic Monitoring Survey.

For two of the three categories of resources — physician work and practice expenses — each medical procedure is now measured relative to all other procedures according to the amount of resources used. The third element — resource-based malpractice insurance expense — is being incorporated into the fee schedule for 2000.

The fee schedule allowance for a procedure equals the sum of the three rankings, expressed as relative value units (RVUs), adjusted for payment locality cost differences and multiplied by a conversion fact that translates RUVs into dollars.

The relative values for physician work — the physician's own time and effort and the intensity of the procedure — have been established since the inception of the Medicare fee schedule. In 1994, Congress instructed HCFA to design a similar resource-based value system for physician practice expenses. The law required the new payment system to be budget neutral, meaning total physician payments cannot exceed what they would have been without the changes. ◆

Mass Media Flu Campaign Project Is Now Underway

According to the latest scientific evidence and expert opinion by HCFA's first evidence-based report, interventions which included mass media campaigns were more effective than interventions without mass media campaigns in increasing the use of preventive services among African Americans.

HCFA's Good Neighbor Flu Project is testing the theory and contracting with the *Baltimore Sun* to advertise clinic locations, provide information on the efficacy of the flu and pneumococcal shots and provide a call-in service. Among other effective mass media campaign activities are the following:

• The Mass Transit Administration will advertise slogans on promoting flu shots on the side of city buses.

• Radio One and Morgan State University will run public service announcements promoting awareness of flu and pneumococcal vaccinations.

• The "Standing in the Safety Zone" video will be used, as well as Andre Braugher and Kurt Schmoke public service announcements during the upcoming flu season.

These activities are intended to increase the rate of flu shots among African-American and Hispanic Medicare beneficiaries living in the City of Baltimore.

The Good Neighbor Flu Project will also kick-off its third annual "Celebrating Seniors Day" program on October 9 from 10:00 a.m. to 3:00 p.m. at Mondawmin Mall in Baltimore City.

Stepping Out Productions Dancers, the Friendship Missionary Baptist Church Choir of Glen Burnie, the Waxter Senior Center High Steppers, Wenda Royster, and Bea Gaddy are just some of the entertainment for the event. There will be free giveaways (tote bags, free lunch, and dinner at local restaurants, theater tickets and many more goodies).

Thirty-five clinics are scheduled for the Baltimore area, including four at local churches.

This year we are ready to raise those shot rates and ensure that all seniors are immunized and protected against flu and pneumococcal diseases.

Jackie Harley, a health insurance specialist in HCFA's Office of Clinical Standards and Quality, contributed this article.

Selected Health Issues on the Web

http://www.nejm.org/content/1999/0341/0005/TOC.asp

The New England Journal of Medicine, Volume 341, Number 5, July 29, 1999.

The Intensity of Physicians' Work in Patient Visits — Implications for the Coding of Patient Evaluation and Management Services. Subscribers to the print version are invited to log on to the complete text in the *Journal*.

http://www.gao.gov/new.items/he99171.pdf

Prescription Drug Benefits: Impact of Medicare HMOs' Use of Formularies on Beneficiaries. T-HEHS-99-171. July 20, 1999.

"To help beneficiaries compare Medicare+Choice plans and make informed health care decisions, they need clear and easily understood information that includes the drugs the formularies cover, how formulary changes are handled, and policies and procedures for requesting coverage for nonformulary drugs."

Once archived, any individual GAO report may be retrieved directly from the archive in text and PDF formats with the following URL: ***http://www.gao.gov/cgi-bin/getrpt?RPTNO***, replacing RPTNO with report number T-HEHS-99-171.

In addition to the Congressional testimony on the above subject, GAO also reported to Congress on the same subject. That report can be found at ***http://www.gao.gov/new.items/he99166.pdf***

The report is numbered HEHS-99-166, which concludes that "evaluating the prescription drug benefits Medicare HMOs offer is an important but challenging undertaking for prospective enrollees."

http://www.access.gpo.gov/su_docs/fedreg/a990730c.html

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2000 Rates.

On pages 41489– 41641 of the Friday, July 30 *Federal Register* Congress published their revision to the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs. The above URL links to the Table of Contents where four links relate the entire document under the Health Care Financing Administration (HCFA), HHS.◆

New Regulations/Notices

Medicare and Medicaid Programs; Announcement of Additional Applications from Hospitals Requesting Waivers for Organ Procurement Service Areas [HCFA–1055–NC] — Published 8/9. This notice announces additional applications that HCFA has received from hospitals requesting waivers from entering into agreements with their designated organ procurement organizations (OPO). Section 1138 (a)(2) of the Social Security Act allows the Secretary of the Department of Health and Human Services to grant waivers to hospitals that want to enter into an agreement with a specific OPO that is not the designated OPO for the hospital's service area. This notice requests comments from OPOs and the general public for HCFA's consideration in determining whether these waivers should be granted. Comments will be considered if HCFA receives them at the appropriate address no later than 5 p.m. on October 8, 1999. Mail written comments (an original and three copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1055–NC, P.O. Box 9016, Baltimore, MD 21244-9016.

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities [HCFA–1913–F] — Published 7/30. This final rule responds to comments submitted by the public on HCFA's May 12, 1998 interim final rule, that implemented provisions in Section 4432 of the Balanced Budget Act of 1997 regarding Medicare payment for skilled nursing facilities services. This legislation established a prospective payment system, a consolidated billing provision, and a number of related changes. These regulations are effective on September 28, 1999.

Medicare Program; Replacement of Reasonable Charge Methodology by Fee Schedules [HCFA–1010–P] — Published 7/27. HCFA is proposing to implement fee schedules to be used for payment of services, excluding ambulance services, still subject to the reasonable charge payment methodology. The authority for establishing these fee schedules is provided by section 4315 of the Balanced Budget Act of 1997 (Public Law 105-33), which adds to the Social Security Act a new section 1842(s). A fee schedule for ambulance services is mandated by a different statutory provision. Section 1842(s) of the Social Security Act specifies that statewide or other areawide fee schedules may be implemented for the following services: medical supplies; home dialysis supplies and equipment; therapeutic shoes; parenteral and enteral nutrients, equipment, and supplies; electromyogram devices; salivation devices; blood products; and transfusion medicine. Comments will be considered if HCFA receives them at the appropriate address, as provided below, no later than 5 p.m. on September 27, 1999. Mail an original and three copies of written comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1010–P, P.O. Box 26688, Baltimore, MD 21207-0488.

Medicare and Medicaid Programs; Appeal of the Loss of Nurse Aide Training Programs [HCFA–2054–IFC] — Published 7-23. This interim final rule revises current Medicare and Medicaid regulations to provide participating nursing facilities, skilled nursing facilities, and dually participating nursing facilities an opportunity for an evidentiary hearing before an administrative law judge to challenge a facility's loss of its approved nurse aide training program. This rule also amends Medicaid regulations to permit states to provide evidentiary hearings for facilities that participate only in the Medicaid program and that face a loss of their nurse aide training programs. Previous regulations have provided only for an informal hearing when facilities lose training programs and do not otherwise face enforcement remedies under the Medicare and Medicaid programs. These regulations are effective July 23, 1999. Comments will be considered if HCFA receives them at the appropriate address no later than 5 p.m. September 21, 1999. Mail an original and three copies of written comments to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–2054–IFC, P.O. Box 9010, Baltimore, MD 21244-9010; Room 443-G, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201, or Room C5-16-03, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities — Update [HCFA–1056–N] — Published 7/30. This notice sets forth the updates required in Section 1888(e) of the Social Security Act, as added by Section 4432 of the Balanced Budget Act of 1997, related to Medicare payments and consolidated billing for skilled nursing facilities. This notice is effective October 1, 1999. This notice is a major rule as defined in Title 5, United States Code, section 804(2). Pursuant to 5 U.S.C. section 801(a)(1)(A), HCFA is submitted a report to the Congress on this notice on July 30, 1999.

Medicare and Medicaid Programs; Hospital Conditions of Participation; Patients' Rights [HCFA–3018–IFC] — Published 7/2. This rule introduces a new Patients' Rights Condition of Participation (CoP) that hospitals must meet to be approved for, or to continue participation in, the Medicare and Medicaid programs. The interim final rule with comment period sets forth six standards that ensure minimum protections of each patient's physical and emotional health and safety. These standards address each patient's right to notification of his or her rights; the exercise of his or her rights in regard to his or her care; privacy and safety; confidentiality of his or her records; freedom from constraints used in the provision of acute medical and surgical care unless clinically necessary; and freedom from seclusion and restraints used in behavior management unless clinically necessary. The issue of patients' rights has been a longstanding concern for the Health Care Financing Administration. In December 1997, HCFA published a proposed rule that introduced the proposed revision of all hospital CoPs, including a new Patients' Rights CoP. Work to finalize the complete revision of the hospital CoPs continues, however, the Patients' Rights CoP is being finalized separately in an accelerated time frame as recent reports have evidenced a pressing need for the codification and enforcement of these fundamental rights. Of particular concern is the danger posed to patient health and safety by violations of basic patients' rights, such as freedom from restraints and seclusion. The Patients' Rights CoP, including the standard regarding seclusion and restraints, applies to all Medicare- and Medicaid-participating hospitals, that is, short-term, psychiatric, rehabilitation, long-term, children's, and alcohol-drug. These regulations are effective August 2, 1999. ◆

Managed Care Plan Offered to More Medicare Beneficiaries in Additional San Diego County Areas

The University of California, San Diego, made a request to expand its managed care coverage to Medicare beneficiaries over an extended service area and HCFA gave its approval on July 27, 1999.

Doing business as UCSD Senior Health Plan, the University of California, San Diego, began enrollment last month to serve Medicare beneficiaries starting September 1, 1999, in additional areas of San Diego County, including part of Carlsbad, El Cajon, Escondido, Lakeside, Poway, Oceanside, San Marcos and Vista. The plan formerly served beneficiaries in only central San Diego County. About 80,000 eligible Medicare beneficiaries live in the plan's newly approved service area.

Currently, about 6.5 million Medicare beneficiaries — out of a total of nearly 40 million aged and disabled Americans — have enrolled in Medicare HMOs. Thus far, HCFA has approved 22 applications thus year for new or expanded service areas and has an additional 24 applications from managed care organizations seeking to serve beneficiaries in either new or expanded service areas.

Managed care and other new health care options, known as Medicare+Choice, are available where private companies choose to offer them. Original fee-for-service Medicare, currently chosen by more than 33 million beneficiaries, is available to all beneficiaries.

"We are pleased to see that UC-San Diego will begin to serve Medicare beneficiaries in an expanded area of San Diego County, starting in September," HCFA Deputy Administrator Michael Hash said. "This is one of several plans that is entering the growing Medicare managed care program, providing more health plan choices to our elderly and disabled. There's no question that the Medicare+Choice program remains strong."

Congress created Medicare+Choice in the Balanced Budget Act of 1997 to expand the types of health care options available to Medicare beneficiaries. As part of Medicare+Choice, Medicare now offers new preventive benefits and patient protections, as well as a far-reaching information program that includes a national toll-free phone number — 1-800-MEDICARE (1-800-633-4227) — a new Internet site — ***www.medicare.gov*** — and a coalition of more than 200 national and local organizations to provide seniors more information. ◆

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